

INCREASED COMPETITION AND THE TRANSFORMATION OF CONNECTICUT'S HOSPITALS INTO INTEGRATED DELIVERY SYSTEMS

INTRODUCTION

The 1990s witnessed transformations in both the structure of Connecticut's acute care hospitals and the services that they offered. Hospitals experienced "vertical integration," an expansion in their range of services beyond acute care, and "horizontal integration," mergers and affiliations between themselves and other health care institutions. They pursued integration strategies in order to increase their range of markets and to expand their geographic service areas. Hospital administrators also hoped that mergers and affiliations would increase efficiency and promote administrative and labor cost savings.

Hospitals' use of integration strategies to increase market share was catalyzed by increased fiscal pressures, a more competitive market for health care services, advances in medical technology, changing patterns in the delivery of care, and increased consumerism. Throughout the 1990s, increased operating expenses and stagnant revenues threatened the financial equilibrium of hospitals. Key factors in this were declining reimbursements by commercial and government payers (particularly following the Balanced Budget Act of 1997), the increased cost of advanced medical technologies and therapies, and the tight labor market. Beginning in Fiscal Year 1995, hospitals were also operating in a more competitive market for health care services. While market forces and the spread of managed care helped to slow the growth of health care costs, they also provided an environment in which hospitals assumed greater financial risk and many of the existing pressures upon them intensified.

Hospitals also faced strong competition from physician offices, independent diagnostic laboratories, imaging centers, and ambulatory surgery clinics. An additional factor that added to the pressure upon hospitals was the rising level of consumer expectation regarding quality and convenience of care. Consumer behavior increasingly reflected these new priorities, and hospitals had to find new ways to attract and serve their patients. Through integration strategies, many hospitals adjusted to the new health care market by diversifying their range of services and changing the way they delivered care.

THE CREATION OF A COMPETITIVE HEALTH CARE MARKET

Prior to the mid-1990s, competition in the Connecticut health care market, particularly between hospitals, was quite limited. In a competitive market, providers contend for market share through competitive pricing as well as through the range and quality of their services. They also face risk as they must minimize their costs and deliver services efficiently in order to maximize

their revenues. Conditions for a competitive health care market did not exist in Connecticut because the state extensively regulated the industry, and particularly its acute care hospitals, until spring 1994. From Fiscal Year (FY) 1974 until FY 1994, the Commission on Hospitals and Health Care (CHHC) reviewed and approved the financial operations of health care facilities including rate schedules, capital budgets, gross and net operating revenue, and net expenses.¹ Price competition is the cornerstone of competitive markets, and until 1994 Connecticut hospitals did not have the ability to set their own fees.

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Hospitals were also limited by the Certificate of Need Program (CON), a mandatory examination by the CHHC of all health care institutions' proposed acquisitions or divestments of significant medical equipment or services. The CON process was designed to reduce duplication and fragmentation of health care services while assuring the broadest access to these services. In practice, it was quite restrictive and limited the flexibility of hospitals to determine their range of services.

Concerned with the rising health care costs of the early 1990s, the Connecticut General Assembly increased competition by reducing the state's regulatory role of the health care market. In P.A. 94-9, the Legislature terminated the state's authority to set hospital rates and on the revenue side, removed any restrictions on discount rates and payment arrangements that hospitals negotiate with managed care payers. In July 1994, it abolished the Commission on Hospitals and Health Care and replaced it with the Office of Health Care Access (OHCA) (P.A. 94-3). OHCA inherited responsibility for the CON process, auditing hospitals' financial results, maintaining an inpatient database, and carrying out health care research and planning. In 1998, the General Assembly approved OHCA's request (P.A. 98-150) to streamline the CON process in order to make it a less stringent and more flexible health system planning tool suited to the evolving health care market.²

These legislative reforms established the framework for a more competitive health care market. Hospitals gained the ability to competitively set prices and, with reform of the CON process, they achieved greater control over their range of services. Thus, they can compete with each other and other health care facilities on the basis of

their quality of care, rates, and range of services. Hospitals also assumed greater financial risk, and while this generated incentives for the delivery of more efficient and less expensive care, it also increased the pressures that can threaten financial stability.

FISCAL PRESSURES OF THE COMPETITIVE HEALTH CARE MARKET

While acute care hospitals had gained greater independence in the new competitive health care market, they also faced strong challenges. Government and commercial payers emerged as the primary forces shaping Connecticut's new competitive health care market. By the late 1990s, government was the primary payer for 60% of total statewide inpatient hospital charges.³ At the same time, managed care companies had enrolled over one million state residents and were able to leverage their size into influence over hospital finances and delivery of care. In addition to the government and commercial insurers, hospitals experienced intense competition from independent freestanding clinics and physician offices that offered services once only available at hospitals. Hospitals have also had to adjust to the development of consumerism in the health care market. They must now attract discriminating consumers who are better informed due to the explosion of accessible health care information on the Internet, and who, due to increased co-payments, have a financial incentive to make careful decisions about their health care.

Payers emerged as the primary factors influencing the new health care market, the two most important being managed care and government. Deregulation and the removal of restrictions upon negotiated discount rates created an atmosphere more conducive for managed care and

fostered increased competition between hospitals to attract and retain managed care payers. Enrollment in HMOs grew by 30% from one million people in FY 1995 to 1.3 million in FY 1998.⁴ That year, government was the primary payer for 60% of total inpatient charges as total Medicaid and Medicare gross revenues for Connecticut were \$800 million and \$3 billion respectively.

Payers naturally want to hold down their costs; managed care companies face market incentives to minimize costs as well. Federal and state governments, saddled with growing deficits, also face pressure from the public to rein in spending. By the mid-1990s, Connecticut spent about one-third of its state budget on health care; the cost of the state's Medicaid program was increasing annually by 30%.⁵ Connecticut's Medicaid program is among the most extensive in the country and the state has one of the lowest rates of uninsured, 7% to 8.5%.⁶ Growing health expenditures threatened to bring the state government over its constitutionally-mandated spending cap. At the national level, the federal government is the country's largest purchaser of health care services, spending \$507 billion in 1997. By the mid-1990s consensus was building in Congress to limit the growth of health care expenditures.⁷

Managed care companies limited their expenses by negotiating contracts in which hospitals agreed to be reimbursed based upon a fee schedule—a listing of diagnostic codes and services with pre-established payment amounts—or on a per capita rate, “capitation.” This was a departure from the traditional fee-for-service system under which physicians and other providers were reimbursed based upon their billed charges. Under the new payment methods with their

pre-established reimbursements, hospitals and all health care providers accepted significantly more of the financial risk for treatment.⁸ Immediately following the General Assembly's 1994 annulment of the 3.5% cap on all discount rates, the number of agreements between hospitals and managed care companies jumped from 163 to 560. As a result, the average managed care discount rate for acute care hospitals expanded by 244%.⁹ The discount rate that a hospital is able to negotiate has a significant impact on its revenue streams and financial performance. From FY 1994 to FY 1998, the statewide average discount rate grew from 9% to 29.8% of total hospital charges, which totaled \$2.25 billion in FY 1998.

Managed care companies also affected hospital revenues through utilization review of services and the use of practice protocols.¹⁰ Their influence contributed to steadily increasing outpatient volume, reduction in the length of inpatient stays, and to the growing number of patients being discharged to less expensive (relative to acute care beds) residential facilities, outpatient clinics, and home health care.¹¹

Like managed care organizations, state and federal governments sought to slow the growth of their health care reimbursements. In order to control health care expenses, Medicare and Medicaid managed care (“Connecticut Access”) were introduced in FY 1995. Connecticut Access was implemented more quickly and, by FY 1998 accounted for nearly 40% of Medicaid's gross revenues while Medicare managed care accounted for about 12%.¹²

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Nationally, forty-nine states have Medicaid managed care programs that cover one-half of all enrollees.¹³ By the late 1990s, Medicare and Medicaid managed care succeeded in slowing the growth of the federal government's health care expenditures; in 1997 the lowest annual increase in 35 years was recorded.¹⁴ Declining welfare rolls due to the U.S. Congress' passage of the Personal Responsibility and Work Opportunity Act of 1996 and the strong economy were also significant factors slowing the growth of Medicaid spending. For Connecticut, gross revenue for Medicaid grew by only 4% from FY 1996 to FY 1998 and 11% for Medicare.¹⁵ In FY 1998, Medicaid and Medicare reimbursements were respectively 71.6% and 97.9% of Connecticut hospital costs.¹⁶

The Balanced Budget Act of 1997 (BBA) further constrained Medicare payments.¹⁷ The BBA also reduced the rate at which Medicare and Medicaid reimburse teaching hospitals for graduate medical education (GME). In FY 1998, seventeen Connecticut hospitals received a total of \$164.4 million, an 8% drop from the prior year.¹⁸ OHCA estimates that between 1998 and 2002 the reduction in GME payments from Medicare will be .86% of the total combined operating revenue for all of Connecticut's teaching hospitals, or \$25.6 million. Together, managed care and the govern-

Revenues nearly mirrored operating expenses as annual growth in total net revenue also fell from around 3% to 1%. As a result, the statewide hospital gain from operations declined precipitously from \$105 million in FY 1996 to \$13 million in FY 1998; the financial stability of Connecticut's acute care hospitals decreased as well.²⁰

In addition to payers, the competitive health care market, and particularly the appearance of new rivals, affected hospital revenues. Although the market did not really generate strong competition among Connecticut hospitals or from those in neighboring states, it did foster intense competition between them and independent freestanding facilities and physician offices.²¹ These specialty facilities and physician practices compete with hospitals by offering ambulatory care, sometimes including surgery, and diagnostic services such as radiology and imaging. The primary specialties for office-based surgery are ophthalmology, orthopedics, and urology.²² They are in a relatively strong competitive position because they can be selective about the services they offer. In addition, unlike hospitals, they can also be selective about the patients they serve; they do not have to treat the indigent and can turn away low-reimbursement patients such as those on Medicaid and Medicare.²³

Exhibit 5: Total Connecticut Hospital Operating Expenses and Net Revenue, FY 1993 to FY 1999 (\$ billions)

	1993	1994	1995	1996	1997	1998
Total Operating Expenses	3.48	3.6	3.6	3.6	3.7	3.8
Total Net Revenue	3.5	3.6	3.7	3.8	3.8	3.8

Source: CT Office of Health Care Access Annual Reports on the Financial Status of Connecticut's Acute Care Short-term General Hospitals. Figures have been rounded.

ment limited hospital operating expenses and revenue (Exhibit Five). With the advent of managed care and the competitive market, the annual growth of hospital total operating costs fell from 4% to 3%.¹⁹

Another advantage enjoyed by these facilities and physicians' offices is that they are often in convenient suburban locations. In addition, they are not as stringently regulated. By statute, CON regulations only apply to "free-standing facilities" and OHCA has, in practice, not included most physician offices under this term. However, many of these offices have been accredited by the American Association of Ambulatory Care Facilities so that they can receive Medicare reimbursements.

Many hospital administrators think that ambulatory care and diagnostic facilities have reduced patient volume for some of their most profitable services.²⁴ As a result, hospitals are limited in their ability to shift costs from other expensive and less profitable services, such as from the Emergency Room to outpatient surgery.²⁵ Competition from ambulatory surgery centers did, however, provide an incentive for hospitals to establish their own ambulatory surgery centers and, more generally, to increase outpatient care.

Hospitals have also had to adjust to the development of consumerism in the health care market. Consumers are generally better informed and they want high quality, convenient care.²⁶ Due to expanding co-payments, patients also have a financial incentive to make careful decisions about their health care. Consumer behavior is, therefore, increasingly reflecting these new concerns regarding quality, cost, and convenience; providers are being forced to respond. Part of the success of ambulatory care centers is their ability to meet these new consumer demands.

HOSPITALS RESPOND TO FINANCIAL PRESSURES: THE DEVELOPMENT OF INTEGRATED HEALTH SYSTEMS

Hospitals responded to the financial pressures of managed care and the new competitive market with cost containment measures, changes in delivery of care, and an expansion in their range of services. They began to evolve into “integrated health systems,” health care institutions that offer a broader scope of services than acute care to a more geographically diverse population.²⁷

Integrated health systems develop through two processes. “Vertical integration” occurs when hospitals expand their array of health care services beyond acute care.

Many Connecticut hospitals, for example, offer preventative and primary care, run outpatient behavioral health and physical therapy clinics, own nursing and residential care facilities, and licensed home health care services. Vertical integration brought hospitals into competition with many other types of health care providers.

The second process for development of integrated health systems, “horizontal integration,” refers to affiliations that hospitals negotiate with each other and other types of providers.

Connecticut hospitals have entered into these arrangements in order to pool and consolidate their resources, to fund joint services, to contract with home health agencies, and to provide rehabilitation services.²⁸ By FY 1998, at least 20 of the state’s 31 acute care hospitals had established affiliations with other Connecticut hospitals. In addition, Day Kimball Hospital of Putnam established an affiliation with the University of Massachusetts Medical Center, New Milford Hospital created an alliance with Columbia-Presbyterian Medical Center of New York, and Yale-New Haven negotiated a loose affiliation with Westerly Hospital, Rhode Island.

Vertical Integration.

Vertical integration has been a fairly common response of hospitals to the pressures associated with Connecticut’s competitive health care market. As Connecticut recovered from the recession of the early 1990s, hospitals could afford to make capital investments to improve

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their competitiveness. From FY 1994 through FY 1998, the Office of Health Care Access approved 226 Certificates of Need (CONs) with capital expenditures of over \$809 million.²⁹ One-quarter of these CONs authorized new services as hospitals sought to increase their share of the health care market beyond acute care (See Exhibit Six). Twenty-two percent of all CONs approved the purchase of imaging and major medical equipment as hospitals tried to compete with independent ambulatory care and diagnostic facilities. A further 11% of the CONs authorized the renovation or construction of new facilities as many hospitals constructed ambulatory care centers, assisted living and nursing homes, and improved their physical facilities. While physical plant renovations are often cyclical in nature, several hospitals have made changes to improve the atmosphere of their buildings. During this period, one-half of the acute care hospitals also upgraded or replaced their management information systems. Advanced information systems are necessary to facilitate development of integrated health systems, because they can provide multiple health service professionals with clinical information about patients as they receive care at many different points within the integrated health system.

Over 20% of the CONs were related to hospitals' implementation of new services; the most frequent additions were in



behavioral health care services. Some hospitals acquired established mental health facilities, others created new ones, while still others instituted newer behavioral health programs such as outpatient substance abuse treatment services. However, due to financial losses at the end of the decade, many hospitals have sought to limit or even drop their behavioral health programs.

Two-thirds (20) of Connecticut hospitals have expanded their range of services to

include primary and preventative health and one-half (16) have freestanding clinics that offer ambulatory care and diagnostic services such as MRIs. Quite a number of hospitals have chosen suburban locations for these facilities. At least 13 of the 31 acute care hospitals have physical therapy or rehabilitation clinics. The state boasts six invasive cardiology centers and four Level 1 Trauma Centers. In addition, from FY 1994 to FY 1998, there were seven hospitals that received authorization to open student health clinics. In a more competitive market, hospitals must compete for consumers who are concentrated in suburban locations and who are increasingly demanding convenient care. By placing family health centers, wellness clinics, imaging centers, and ambulatory care facilities in suburban locations, hospitals are trying to more effectively compete with the independent free standing health care facilities that have proliferated since the deregulation of Connecticut's

health care market. Although Connecticut's hospitals remain non-profit institutions, 18 of them have for-profit health care services divisions.

As the population ages and an increasing proportion of inpatients are being discharged to skilled nursing and long-term care facilities, one-half (15) of all hospitals have constructed or acquired convalescent homes, nursing and long-term care facilities, and assisted living institutions. With shorter inpatient stays, home health care services have become an important part of health care; at least 19 hospitals offer these services.

Hospitals have not only expanded the range of medical services they offer, twelve of them have also become insurers. Eighteen hospitals also license either Physician-Hospital Organizations, legal entities that negotiate with managed care companies, or Management Service Organizations, legal entities providing administrative and support services to physicians. Yale-New Haven Health Services Corporation licensed Yale Preferred Health, Inc., a for-profit managed care organization. Medspan, another for-profit HMO, is owned by the corporate parents of Hartford, MidState, St. Raphael's, New Britain, Bradley Memorial, and Charlotte Hungerford Hospitals, along with the Connecticut Children's Medical Center. For some hospitals, becoming insurers or managers of physician practices turned out to be financially detrimental.

In addition to offering new services, hospitals have also made changes in how they deliver acute care, particularly by offering more outpatient care. From FY 1993 to FY 1999, inpatient volume declined by 5% while the number of outpatient visits increased by 23%.³⁰ The increase in outpatient care has been driven by market

incentives for more cost effective care, consumer demands for quicker and more convenient services, managed care pressures, competition from independent ambulatory surgery centers and physician offices, and advances in medical technology and therapies. As with primary care and diagnostic facilities, many hospitals have established suburban outpatient ambulatory care centers.

Horizontal Integration.

Hospitals negotiated a steadily increasing number of affiliations, acquisitions, and joint projects between themselves and other health care institutions in order to pool and consolidate resources, create economies of scale for services, and maximize their leverage for negotiating with managed care companies and other commercial insurers. From FY 1994 to FY 1998, 9.3% of all CONs authorized mergers and acquisitions.

During the 1990s, the number of acute care hospitals declined from 36 to 31 as financially troubled Mt. Sinai, Park City, and Saint Joseph's Hospitals were absorbed respectively by St. Francis, Bridgeport, and Stamford Hospitals. These facilities remain open although they have shifted from offering acute care to either outpatient services or critical care. Winsted Hospital closed, and in its place a community health center was formed with Charlotte Hungerford and St. Francis providing clinical services. In addition, The MidState Medical Center was formed following the merger of Meriden-Wallingford and World War Two Veterans Memorial Hospitals.

While hospital mergers were the most dramatic and, to some people, the most troubling aspect of horizontal integration,

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they were not commonplace. At least 20 of Connecticut's existing 31 acute care hospitals negotiated affiliations with other hospitals. These agreements ranged from those that created a common parent corporation but left the hospitals as units within the new integrated health system, to those that fostered cooperation in just one or a few service areas (See Appendices 2 and 3). Four integrated health care delivery systems have emerged within Connecticut:

- ◆ The Central Connecticut Health Alliance with New Britain General and Bradley Memorial Hospitals



- ◆ The Eastern Connecticut Health Network with Manchester Memorial and Rockville General Hospitals
- ◆ The Hartford Health Care Corporation with Hartford Hospital and MidState Medical Center
- ◆ The Yale-New Haven Health Services Corporation with Yale-New Haven, Bridgeport, and Greenwich Hospitals. Norwalk Hospital is a network participant but not full affiliate of this system.

These delivery systems each have a common parent corporation, share common planning, and have generally taken steps to integrate their information systems. Yale-New Haven also expanded its integrated delivery system by acquiring the Temple Medical Group, radiology and outpatient facilities, while Hartford Health Care Corporation added the Visiting Nurse Association and behavioral health facilities such as Natchaug Hospital and the Rushford Center. The Central Connecticut Health Alliance acquired the Reid Treatment Center, a behavioral health facility. In addition to the four Connecticut delivery systems, Day Kimball Hospital in Putnam is an affiliate of the UMASS Medical Center and its parent corporation, HealthNet of New England, while New Milford, Stamford, and St. Vincent's have loose affiliations with the New York Presbyterian System. In FY 1996, Saint Francis and Bristol Hospitals signed an agreement to form an integrated delivery system. Although they formed an affiliation corporation, it does not act as the parent corporation. In FY 1998, they gained CON approval to begin implementing an integrated information system.

More numerous than the affiliations that created integrated health systems were those that instituted joint ventures and examined the possibility of future system partnership but did not include corporate mergers or restructuring. Yale-New Haven Health Services has negotiated two such affiliations. Hartford Health Care has five with other acute care hospitals and one with the Hospital for Special Care, a rehabilitation facility in New Britain.

Hospitals also negotiated several agreements that were distinct from affiliations because they fostered cooperation in only one or a few service areas. For example, Bristol, Milford, and Griffin Hospitals formed the Western MRI Consortium to

share a mobile MRI scanning unit. Bridgeport, William Backus, and Lawrence and Memorial Hospitals coordinate their cancer care with Yale-New Haven as part of the Yale Oncology Network. Lawrence and Memorial and William Backus Hospitals along with GAMBRO Health Care, LLC, co-founded a kidney dialysis center in New London.

Acute care hospitals have also negotiated affiliation agreements with other types of health care organizations. Through these agreements, hospitals have entered into joint ventures that extend their range of services into such fields as physical and occupational therapy, home health care, nursing and residential facilities, behavioral health, and primary care. Hospitals have also created arrangements with private corporations that manage their real estate holdings or provide them with management, billing, and collection services.

Many of Connecticut's acute care hospitals have responded to fiscal pressures, medical technology advances, and changes in the delivery of care with integration strategies. Through horizontal and vertical integration, these hospitals have increasingly become components of integrated health systems that are able to offer patients a broader spectrum of health care services. Additionally, integrated health systems should have an increased share of the health care market over traditional acute care hospitals. A key question is whether integrated health systems and other affiliations have enhanced fiscal stability and quality of care.

Integration and affiliation agreements are relatively recent phenomena in Connecticut and, unfortunately, there is little empirical evidence with which to answer this question. Fiscal pressures

on all hospitals have continued to intensify. Some hospital administrators have observed that this has slowed integration because hospitals are concerned with short-term survival and cannot make the capital investments needed to link their facilities with others. It does appear that the hospitals experiencing the greatest financial distress are those that did not actively pursue integration, however, other factors may be responsible for this. In addition, not all integration strategies turned out to be successful. In general, integrated systems should have more leverage to negotiate with managed care companies. However,

the empirical evidence on this is mixed as the Hartford Health Care Corporation and Yale-New Haven Health Services Corporation hospitals generally had managed care discount rates below the statewide average, while the rates of hospitals in the Central Connecticut Health Alliance and the Eastern Connecticut Health Network were above it. Contributing to the strength of the former two systems is that they are composed of larger, tertiary hospitals while the latter two are composed of smaller facilities.

On the cost side, hospitals enter into affiliations to gain administrative and labor cost savings. Whether as the result of horizontal integration or not, the number of full time equivalents at acute care hospitals decreased by 8% from 46,304 in FY 1993 to 42,500 in FY 1998. As hospitals experienced staff reductions, employment in the health care industry grew by nearly 23% in the 1990s, an addition of 28,700 jobs. The contrast of hospital and health care employment illustrates the changing

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nature of the health care industry, particularly in the delivery of medical services.

Little empirical evidence exists to examine the effects of affiliations and integration upon quality of care. Integration has expanded the number of services available to patients through hospitals and their

affiliated networks of providers. Affiliations allow patients to go outside of their geographic vicinity to network facilities that have more experience or expertise with a particular service. Unfortunately, these advantages may be offset in consumers' minds by changes in quality of service brought on as a result of staff reductions.

CONCLUSION

The establishment of a competitive market for health care services in the mid-1990s catalyzed profound changes in Connecticut's acute care hospitals. While market forces and the development of managed care helped to slow the growth of health care costs, they also provided an environment in which hospitals assumed greater financial risk and many of the existing pressures intensified, particularly with regard to revenues. From FY 1996 to FY 1998, the statewide gain from operations fell from \$105 million to \$13 million and, as a result, the financial stability of Connecticut's hospitals decreased. Hospitals also began to face intense competition from independent freestanding facilities and physician offices that offered ambulatory care sometimes including surgery, and diagnostic services such as radiology and imaging. These competitors are in a strong position relative to the hospitals because they can concentrate on offering the most lucrative services, they are not as stringently regulated as hospitals, and unlike hospitals, they do not have to treat indigent or low-reimbursement patients, such as those on Medicaid and Medicare.

Hospitals responded to the new competitive environment through a combination of cost reduction, "vertical integration"—expanding the range of their services, and "horizontal integration"—negotiating affiliations and mergers between themselves

and other health care institutions. In pursuit of vertical integration, hospitals have expanded their behavioral health facilities, constructed or acquired convalescent homes and skilled nursing facilities, established outpatient and primary and preventative care clinics, and added home health services. Although Connecticut's hospitals remain non-profit institutions, there are now many for-profit units within their systems. Horizontal integration also took place as four distinct integrated health care systems were formed, and a fifth one, involving Saint Francis and Bristol Hospitals, may be emerging. There were also more numerous affiliations and agreements between hospitals that fostered cooperation in limited service areas. Affiliations allowed hospitals to pool and consolidate their resources and to create economies of scale for their services.

The empirical effects of affiliations and integrated health systems upon hospital finances and the quality of care have yet to be determined. In addition, intensifying fiscal pressures may also have hampered integration in the late 1990s as hospitals had to increasingly concentrate on short-term survival rather than on long-term processes such as integration with its associated capital costs. Yet the changes that occurred in Connecticut in the 1990s, and even more so in the rest of the U.S.,

suggest that the health care industry is experiencing a transformation and acute care hospitals are increasingly becoming components of “integrated health systems,” networks of health care institutions that offer extensive arrays of services from primary to hospice care.

RECOMMENDATIONS FROM THE HOSPITAL STUDY FOCUS GROUP

In the summer of 2000, the Office of Health Care Access sponsored a focus group that discussed the competitive health care market and the development of integrated health systems. Members included representatives of hospitals, ambulatory care centers, and the insurance industry. They offered the following recommendations:

- ◆ The State government should “level the playing field,” by creating a more uniform set of regulations that apply to both acute care hospitals and their main competitors, independent freestanding clinics and physician offices. The latter two are less regulated and, unlike hospitals, may turn away patients, particularly those on Medicaid.
- ◆ The State must consider the repercussions of policy and legal changes, especially in terms of specialty groups and credentialing of health care professionals.
- ◆ Improve Medicaid and Medicare reimbursements.

Exhibit 6: Vertical Integration of Connecticut's Acute Care Hospitals, FY 1998 to FY 2000

Hospital	Collection Services	Diagnostic	Health Care	Home Health	Long-term Care	Managed Care	Other Care	Outpatient	Physical Therapy	PHO	Real Estate
William Backus	P	NP		NP	NP		NP	NP	NP		NP
Bradley			P	NP	NP	NP		NP	P	P	
Bridgeport		NP	P	NP		NP,P	NP	NP	NP	P	NP
Bristol								NP		P	
CT Children's Medical Center						NP		NP			
Danbury				NP	NP		NP	NP		P	
Day Kimball	P			NP	NP			NP		P	NP
John Dempsey								NP			
Greenwich						NP		P			NP
Griffin			P			P		NP			
Hartford		P	P	NP,P	NP	NP	P	NP	NP	P	P, NP
Charlotte Hungerford				P			NP	NP	NP		NP
Johnson Memorial		NP	P	NP	NP		NP	NP			
Lawrence and Memorial		NP	P	NP,P	NP		NP	NP			
Manchester Memorial			P	NP			NP	NP			P
Middlesex	NP	NP		NP	NP	P	NP	NP		P	P
MidState		P	P	NP,P	NP	NP	P	NP	NP	P	P, NP
Milford		P	P	P			NP				
New Britain			P	NP	NP	NP	NP	NP	P	P	
New Milford			P*	NP			NP	NP			
Norwalk	NP				NP		P, NP	NP	NP		
Rockville			P	NP	NP		NP	NP			P
Saint Francis	NP				P	NP	NP	NP	NP	P	
Saint Mary's	P	NP,P					NP	P		NP,P	P
Saint Raphael's		NP	P	P	NP	NP	NP,P	NP		NP,P	NP
Saint Vincent's			P	NP	NP		NP	NP	NP	P	NP

Source: CT Office of Health Care Access Fifth Annual Report on the Financial Status of Connecticut's Short-term Acute Care General Hospitals.

The main sources of data for this chart are the corporate organizational charts that the hospitals themselves annually submit to the Office of Health Care Access. Supplemental data has come from the Lewin Group Hospital Site Reports which have been verified by the hospitals, as well as information presented in brochures published by the hospitals.

- ♦ "P" denotes "for-profit" entities and "NP" signifies "non-profit."
- ♦ "Diagnostic" refers to freestanding radiology and imaging centers and laboratories.

- ◆ “Health Care” refers to for-profit health care services.
- ◆ “Home health care” includes home health and visiting nurse services.
- ◆ “Long-term care” includes assisted living facilities, long and intermediate care facilities, convalescent homes, and hospices.
- ◆ “Managed care” denotes managed care and insurance.
- ◆ “Other health care” refers to primary care, pediatric and women’s health clinics, fitness centers, pharmacy, and day care.
- ◆ “Outpatient” includes all outpatient clinics and ambulatory surgery centers.
- ◆ “Physical Therapy” includes rehabilitation, occupational therapy, and physical therapy.
- ◆ “PHO” includes Physician Health Organizations, Management Service Organizations, Billing Services, Physician Billing, Physician Practices, and Management Services.
- ◆ Bradley Memorial Hospital’s data includes all of the units associated with its parent corporation, the Central Connecticut Health Alliance, Inc.
- ◆ Bridgeport Hospital’s data includes all those units associated with its parent corporation, Yale-New Haven Health Services Corporation.
- ◆ Day Kimball Hospital’s data includes all units under its parent corporation, HealthNet of New England.
- ◆ Hartford Hospital’s data includes all units associated with its parent corporation, Hartford Health Care Corporation.
- ◆ MidState Medical Center’s data includes all units under its parent corporation, Hartford Health Care Corporation.
- ◆ New Britain Hospital’s data includes all units under its parent corporation, Central Connecticut Health Alliance, Inc.
- ◆ *New Milford Hospital’s for-profit corporation, the “Twenty-One Elm Street Corporation,” is currently without any operations.
- ◆ Rockville Hospital’s data includes all units under its parent corporation, Eastern Connecticut Health Network, Inc.
- ◆ Yale-New Haven Hospital’s data includes all of the units under its parent corporation, Yale-New Haven Health Services Corporation.

Exhibit 7: Affiliations Among Connecticut's Acute Care Hospitals, FY 1998

Affiliations with a Common Parent Corporation					
COMMON PARENT CORPORATION	Central CT Health Alliance	Eastern CT Health Network	Hartford Health Care Corporation	Yale-New Haven Health Services Corporation	Health Net of New England
HOSPITALS	New Britain Bradley	Manchester Rockville	Hartford MidState	Yale-New Haven Bridgeport Greenwich	Day Kimbal UMASS Medical Ctr.
Affiliations/Alliances without a Common Parent Corporation					
HOSPITALS	With Hartford	With St. Mary's	With Yale-New Haven	With New York Presbyterian Healthcare Network	
	St. Raphael Johnson John Dempsey Charlotte Hungerford	Bristol St. Francis	Norwalk St. Francis The Westerly Hospital, RI	New Milford Stamford St. Vincent's	

Exhibit 8: Chronology of Hospital Mergers and Affiliations since 1992

1992–1994

- ◆ There were no mergers or affiliation activity between any Connecticut hospitals.

1995

- ◆ Saint Francis and Mount Sinai Hospitals merged under one hospital license after affiliating in 1990.
- ◆ Manchester Memorial and Rockville General Hospitals merged parent corporations.
- ◆ New Britain General and Bradley Memorial Hospitals merged parent corporations.

1996

- ◆ Yale-New Haven and Bridgeport Hospitals' parent corporations affiliated.
- ◆ St. Joseph Medical Center was purchased by the parent corporation of St. Vincent's Medical Center (51%) and the parent corporation of Stamford Hospital (49%).
- ◆ New Milford Hospital affiliated with Columbia Presbyterian Medical Center (New York, NY).
- ◆ St. Francis and Bristol Hospitals merged through the creation of a new corporate affiliate.
- ◆ The parent corporations of Hartford Hospital and Veteran's Medical Center (now MidState Medical Center) affiliated.

1997

- ◆ The parent corporations of Yale-New Haven and Greenwich Hospitals affiliated.
- ◆ Hartford and John Dempsey Hospitals affiliated.
- ◆ The parent corporations of St. Francis and St. Mary's Hospitals affiliated.

1998

- ♦ Hartford Hospital established a strategic alliance with the Hospital of St. Raphael's and Charlotte Hungerford Hospital. There is no formal affiliation and no change of control by any of the facilities.
- ♦ The parent corporations of Hartford and Sharon Hospitals affiliated.
- ♦ Connecticut Children's Medical Center (a subsidiary of Hartford Hospital's parent corporation) and MidState Medical Center affiliated.
- ♦ St. Vincent's Medical Center's parent corporation affiliated with New York Presbyterian Healthcare Network.

NOTES

¹Fiscal Year refers to the hospital fiscal year which runs from October 1st through September 30th.

²CON reforms included exempting certain categories of providers, providing waivers for programs endorsed by other state agencies, creating waivers for certain other categories of equipment acquisitions, and re-engineering the dynamics of the CON process itself.

³State of Connecticut Office of Health Care Access Inpatient Database.

⁴State of Connecticut Office of Health Care Access Hospital Budget Reporting System.

⁵CT Office of Policy Management, 1994 Health Care Discussion Group Report To Governor Lowell P. Weicker, Jr. 1994 & KPMG Peat Marwick, 1994. Development Of Recommendations And Plans For Health Reform In Connecticut.

⁶OHCA 1998 Report on Connecticut's Insured and Uninsured & The Center for Disease Control 1998 BRFSS Survey.

⁷Iglehart, John. (1999a) The American Health Care System—Expenditures. *New England Journal of Medicine* 340(1) 70 – 6.

⁸This also limits the ability of hospitals to “cost shift,” that is to charge insured patients more to compensate for their discounted or free care or the low Medicaid reimbursements.

⁹State of Connecticut Office of Health Care Access Hospital Budget System.

¹⁰Iglehart, John. (1999a) The American Health Care System—Expenditures. *New England Journal of Medicine* 340(1) 70 – 6.

¹¹Advances in medical technology also contributed to declining lengths of stay and the expansion of out patient care. State of Connecticut : OHCA Third Annual Report on the Financial Status of Connecticut's Acute Care Short-term General Hospitals.

¹²State of Connecticut Office of Health Care Access Hospital Budget System.

¹³Iglehart, John. (1999b) The American Health Care System—Medicaid. *New England Journal of Medicine* 340(1) 403 - 408.

¹⁴Iglehart, John. (1999a) The American Health Care System—Expenditures. *New England Journal of Medicine* 340(1) 70 – 6.

¹⁵OHCA Annual Reports on the Financial Status of Connecticut's Acute Care Short-term General Hospitals.

¹⁶Lewin Group Analysis of American Hospital Association data.

¹⁷Iglehart, John. (1999c) The American Health Care System—Medicare. *New England Journal of Medicine* 340(1) 327 – 332.

¹⁸State of Connecticut Office of Health Care Access Analysis of Graduate Medical Education, 2000.

¹⁹Nationally, a principal factor in the growth of hospital expenses was the increased capital outlays associated with medical technology (Iglehart, 1999a). In the U.S., medical technology diffuses quickly and it used to treat more patients than in the health care systems of other Western countries. Connecticut hospitals have a sophisticated array of medical services that includes the most advanced technologies (CT Office of Policy Management—OPM, 1994). The rising cost of prescription drugs also significantly contributed to rising health care expenses. During the 1990's, the cost of pharmaceuticals rose faster than any other

component of health care, 85% from 1993 to 1998 alone (Kuttner, 1999). In addition, the cost of physician services contributed to the increased cost of health care, although growth of physician compensation slowed in the 1990's (Iglehart, 1999a).

²⁰Annual Reports on the Financial Status of Connecticut's Acute Care Short-term General Hospitals.

²¹State of Connecticut Office of Health Care Access Hospital Study Focus Group on Competition and Financial Integration, 2000.

²²Meacham, Michael & Gorman, Raymond. (1999) Physician "Office-based" Ambulatory Surgical Center: A Discussion Paper. CT Office of Health Care Access.

²³All Connecticut acute care hospitals are by law required to provide emergency care to any patient who requires it regardless of their ability to pay.

²⁴State of Connecticut Office of Health Care Access Hospital Study Focus Group on Competition and Integration.

²⁵State of Connecticut Office of Health Care Access Certificate of Need Declaratory Ruling, DR99-001.

²⁶State of Connecticut Office of Health Care Access Hospital Study Focus Group on Consumerism, 2000.

²⁷Shortell, Stephen, Gillies, Robin, Anderson, David, Morgan Erickson, Karen, Mitchell, John. (1996) *Remaking Health Care in America*. San Francisco: Jossey-Bass Publishers.

²⁸State of Connecticut Office of Health Care Access Annual Reports on the Financial Status of Connecticut's Acute Care Short-term General Hospitals.

²⁹State of Connecticut Office of Health Care Access Hospital Budget Reporting System.

³⁰State of Connecticut Office of Health Care Access Hospital Budget Reporting System and Inpatient Database.

³¹State of Connecticut Office of Health Care Access Hospital Study Focus Group on Competition and Integration, 2000.

³²State of Connecticut Office of Health Care Access Annual Reports on the Financial Status of Connecticut's Acute Care Short-term General Hospitals.

³³State of Connecticut Department of Economic and Community Development.